LAC DMH
LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
550 S. VERMONT AVE., LOS ANGELES, CA 90020 HTTP://DMH.LACOUNTY.GOV

MARVIN J. SOUTHARD, D.S.W.
Director

ROBIN KAY, Ph.D.
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

September 2, 2014

The Little Hoover Commission
925 L Street, Suite 805
Sacramento, CA 95814

Dear Commissioners:

The Los Angeles County Department of Mental Health (LACDMH) is pleased to provide the following requested information to the Little Hoover Commission as part of its review of the oversight of the Mental Health Services Act (MHSA) and its outcomes and impact.

Annual Process to Allocate MHSA Funds

After engaging in extensive initial community program planning for each of the MHSA components, LACDMH, through its System Leadership Team (SLT) and Service Area Advisory Committees (SAACs), has engaged in annual reviews of services, their effectiveness and the needs of communities throughout Los Angeles County. Both the SLT and the SAACs meet monthly and engage in countywide and local planning, respectively. The composition of the SLT, consistent with the MHSA and AB 1467, is:

- *LA County Chief Executive Office*
- *Representation from each Service Area Advisory Committee*
- *Consumer and family member representation, including NAMI, self-help and the LA County Client Coalition*
- *Department of Public Social Services*
- *Health Care, including the Hospital Association and LA County Department of Public Health, LA County Department of Health Services*
- *LA Police Department*
- *Probation*
- *Housing development*
- *Older Adult service providers and LA County Community and Senior Services*
- *Under-Represented Ethnic Populations, including Asian Pacific Islanders, American Indian, African American, Latino*
- *Clergy*
- *City of Long Beach*
- *Veterans*
- *LA County Mental Health Commission*
- *Unions*
- *Co-Occurring Joint Action Council (substance use disorders and mental illness)*
- *Education, including the LA Unified School District, universities and charter schools*
- *Lesbian, Bisexual, Gay, Transgender and Questioning (LBGTQ)*
- *LA Department of Children and Family Services*
- *LA County Commission on Children and Families*
- *Junior blind*
- *Statewide perspective*

The general process for the county's Annual Update to its MHSA Three-Year Plan is for SAACs to review the service continuum, outcome data for programs and mental health needs for each age group and identified focal population. Information from each of the eight SAACs is communicated to the SLT through its representatives. The SLT reviews all information and makes recommendations to LACDMH on MHSA programs and services. LACDMH then finalizes the Annual Update and posts it for a 30-Day Public Comment period, followed by a Public Hearing convened by the Mental Health Commission and ultimately adoption by the LA County Board of Supervisors.

Once plans are developed and adopted, the allocation of MHSA funding is through a combination of county operated programs and contracts developed as the result of solicitation processes.

The MHSA has served to provide a continuum of services targeting the highest utilizers of institutional programs to those at risk of developing a mental illness. MHSA funds act as both the primary funding source for programs, as well as the match for Medi-Cal services that fund recovery-oriented mental health services and supports. As a result, MHSA funding is embedded within the LACDMH outpatient system of care for children, transition age youth, adults and older adults and is integral to our recovery-oriented outpatient service delivery system.

Mental Health Services Act Programs:

The MHSA funds the following programs, listed by MHSA component:

Community Services and Supports Plan:

Across age groups:

- Full Service Partnership programs
- Field Capable Clinical Services
- Mental Health Urgent Care Centers
- Service Area navigation to aid clients into appropriate services
- Outreach, education and engagement services

Children:

- Family support services

Transition Age Youth:

- Drop-In Centers
- Probation camp services

Adults:

- Wellness and Client Run Centers
- IMD-Step Down facilities
- Permanent supported housing
- Jail linkage and transition to the community

Prevention and Early Intervention:
Prevention approaches focused on preventing mental illness from occurring or early intervention services delivered through evidence-based, promising and/or community defined evidence practices aimed at individuals early in the course of a mental illness. Thirteen different programs, utilizing over 33 evidence-based, promising and community-defined evidence practices:

- Suicide prevention
- School mental health risk reduction
- Stigma and discrimination reduction
- School-based services
- Family education and support
- Services for at risk families
- Trauma recovery services
- Primary care and behavioral health
- Early care and support for transition age youth
- Juvenile justice services
- Early care and support for older adults
- Improving access to underserved populations
- American Indian project to build resiliency and increase protective factors

Innovation:
Three-year projects to test out different models for integrating health, mental health and substance use services, including testing out peer-run services.

Workforce Education and Training:
Investments in developing the skills of the existing workforce and in broadening the workforce through training, academies, tuition reimbursement and stipend programs and collaborations with community colleges and local universities.

Capital Facilities and Technological Needs:
One-time investments to support capital infrastructure needed to provide services and implement an electronic health record.

Process for LACDMH to measure, track and evaluate the outcomes of its MHSA programs:

Overall approach to measures selection: Measures and indicators are selected based on the goals and key interventions associated with each program and with local stakeholder input. Generally, as services reduce in intensity and the target population for services changes to clients with less intensive service needs, program goals and interventions focus more on community integration, wellness and meaningful use of time (including employment, education, volunteering, and community participation). Intensive services such as Full Service Partnership and alternative crisis programs focus on reducing homelessness, incarcerations, psychiatric hospitalizations and emergency room visits. Prevention and Early Intervention metrics were chosen based on input from practice developers, a review of the literature and input from providers and other stakeholders and are specific to the foci of treatment. A general measure and focus of treatment specific measure is administered at the beginning of treatment and at the

end of treatment, with pre- and post-treatment changes analyzed. If the treatment lasts greater than six months, both measures are given again at the six-month marker.

Outcome data collected by program: See appendix for outcome report summaries.

Full Service Partnership (FSP) programs:

Method of data collection: Baseline completed at the beginning of treatment and encompasses the 12 months prior to the client's enrollment date into FSP. Generally reliant on self-report but validated wherever possible by alternative data sources. After enrollment in the program, changes to client status on any of the following domains are entered into a database:

- Living arrangement (including hospitalization, incarceration)
- Source(s) of financial support
- Educational level and status
- Employment status
- Physical health status
- Legal encounters
- Crisis involvement
- Substance use

Results reported: Change in the above domains after enrollment.

Field Capable Clinical Services (FCCS):

Method of data collection: Baseline of current status and six-month updates on the current status of the following data elements:

Living Arrangements:

- Current living arrangements (same categories as FSP)
- Is the client's living arrangement suitable?
- Is the client's living arrangement free from abuse, neglect and domestic violence?
- Is the client satisfied with current living arrangements?

Supportive Relationships:

- Access to at least one stable, supportive adult?

Medical Services:

- Access to needed medical services?
- Receive needed medical services?

Meaningful Use of Time

- Age appropriate involvement in the community?
- Engagement in meaningful activities?

Results reported: Percent of clients endorsing above data elements at baseline and at six-month intervals.

Mental Health Urgent Care Centers (UCC):

Method of data collection: Review of client service history up to 30 days after service at a UCC.

Results reported: Percent of clients who within 30 days of receiving a UCC service have a treatment episode through an inpatient psychiatric unit, psychiatric mobile response team service or Jail mental health contact.

Wellness and Client-Run Centers:

Method of data collection: Limited sampling of clients through a survey every six months.

Results reported: Percent of clients employed, percent of clients in various living arrangements along with general wellness and satisfaction information.

Prevention and Early Intervention:

Method of data collection: Pre-treatment and post-treatment general measure and focus of treatment specific measure given, based on practice (See appendix for PEI Outcome Table).

Results reported: Symptom reduction on measures given before and after an evidence-based practice treatment.

Innovation:

Method of data collection: Client and clinician completed questionnaires completed at baseline and at quarterly intervals, measuring the following domains:

- Level of Service Integration
- Health Status
- Mental Health Status
- Substance Use
- Client Satisfaction
- Community Satisfaction
- Cost Effectiveness

Results reported: Change over time, based on matched pair data, in the above indicators.

Use of outcome reports:
Reports are developed primarily for providers and for LACDMH management. They are used by providers and by LACDMH to determine service effectiveness, to improve service delivery and for administrative decision-making. Reports are also used to demonstrate the impact of the MHSA programs to the legislature, the Board of Supervisors, the Mental Health Commission, the System Leadership Team and to be media upon request.

Challenges in reporting Use of MHSA funds to the State and Recommended Improvements to Reporting:

State oversight should balance an approach operating out of a collaborative respect for local interests and service needs with some level of uniformity in terms of reporting and accountability. County involvement in the development of all MHSA regulations and reporting are critical given that counties have made significant investments in information technology systems, evaluation measures and approaches and administration and evaluation infrastructure. Changes to those investments would require time and resources and could possibly impact service delivery.

Cross-County Learning of Best Practices:
The County Behavioral Health Directors Association of California (CBHDA) MHSA Committee has been instrumental in creating a forum for counties to share best practices related to the administration, implementation and reporting of the impact of MHSA services. The MHSA Committee has also contributed significantly to informing the development of State guidance and regulations related to the MHSA.

The California Institute for Behavioral Health Solutions (CIBHS) has also been instrumental in the identification, training and provision of technical assistance related to evidence-based practices, workforce development and continuous quality improvement practices.

Recommended strategies to inform State oversight of MHSA funds and the role of the CBHDA:

AB 100 realigned MHSA funds to counties, and in the process increased county responsibility and accountability for MHSA services. As a result, the Los Angeles County Mental Health Board assumed the role of approving the LACDMH Annual Updates or Three-Year Program and Expenditure Plan. AB 1467 later dictated that the County Board of Supervisors must adopt the county's Annual Update or Three-Year Program and Expenditure Plan.

CBHDA initiated a county-informed approach to collecting and reporting common outcomes it calls Measurements, Outcomes, Quality and Assessment (MOQA). The initial report issued in February 2014 highlighted dramatic reductions in the number of individuals as well as the number of days adults enrolled in FSP programs were homeless, psychiatrically hospitalized, or incarcerated, large cost offsets associated with FSP services, reduced trauma in children who receive Trauma Focused Cognitive Behavioral Therapy services, high overall client satisfaction and initial service access and timeliness information.

CBHDA is finalizing the methodology for an ongoing approach to creating common behavioral health outcome reporting across counties in order to better tell a statewide story on the substantial impact that the MHSA and behavioral health programs have had on clients and communities.

The Role of CBHDA in determining the annual funding formula:

AB 100 requires that Department of Health Care Services (DHCS) seeks recommendations from a defined set of stakeholders. DHCS did conform to this requirement and has conducted stakeholder conference calls. CBHDA provided written recommendations.

Attached is a summary of outcomes achieved for MHSA programs in Los Angeles County as well as a summary of outcome measures used for each Prevention and Early Intervention practice.

Should you have questions, please do not hesitate to contact me at DIGomberg@dmh.lacounty.gov. I welcome the opportunity to testify before your commission on September 23, 2014.

Best regards,

Debbie Innes-Gomberg, Ph.D.
District Chief, MHSA Implementation and Outcomes Division

DIG:dig

Attachments

c: Marvin J. Southard, D.S.W.
Robin Kay, Ph.D.
Dennis Murata, M.S.W.
Robert Oakes, CBHDA

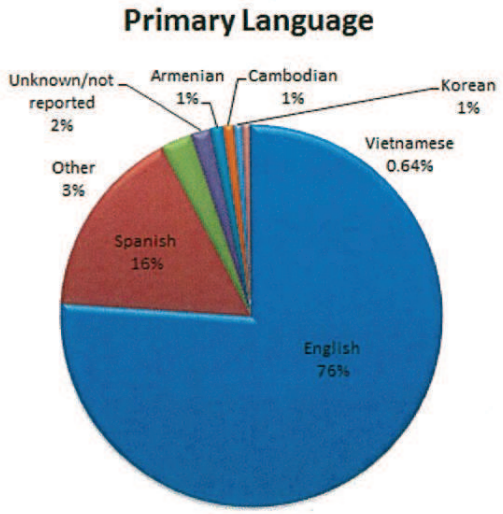
COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH

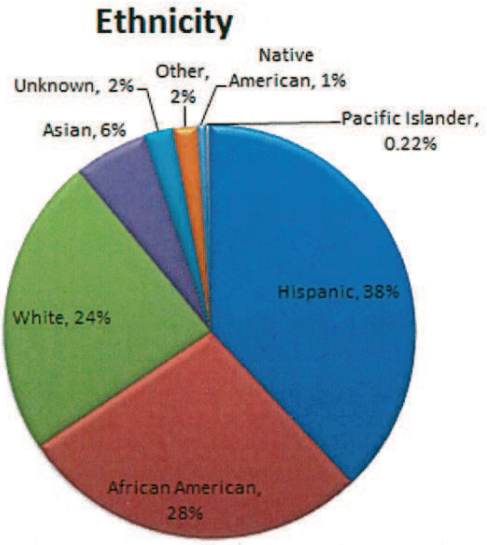
WELLNESS • RECOVERY • RESILIENCE

MHSA PROGRAM OUTCOMES SUMMARY
FISCAL YEAR 2012-13

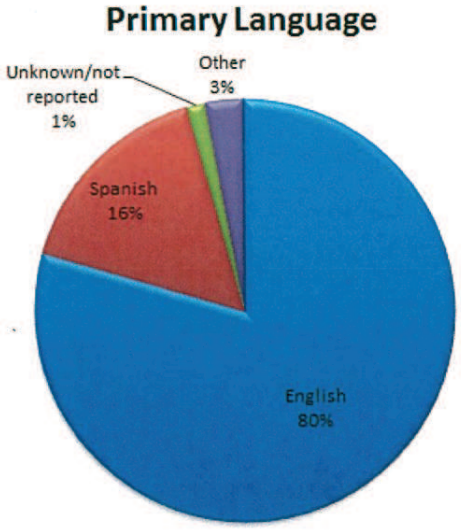
Fiscal Year 2012-13 MHSA Program Community Services and Supports

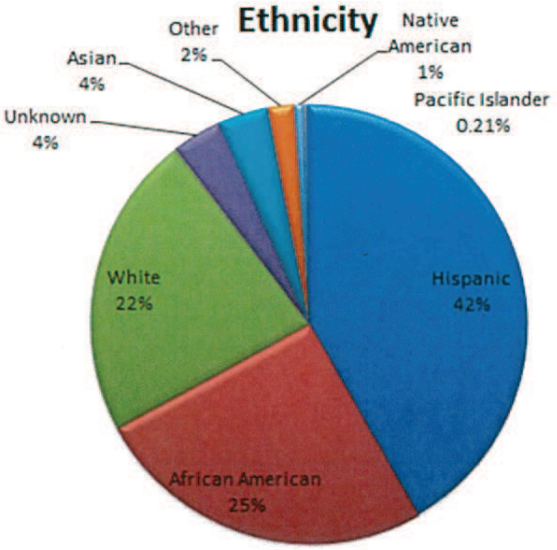
Unique clients receiving a direct Mental Health Service through the CSS Plan: **97,370**





New clients receiving CSS Services Countywide with no previous MHSA Service: **25,093**

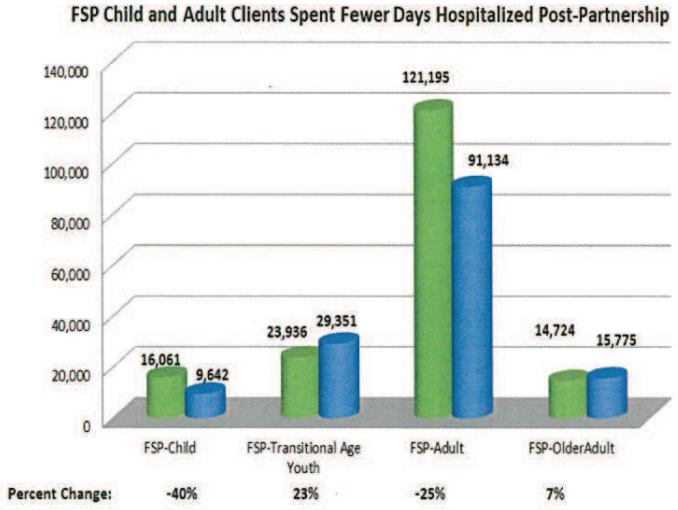


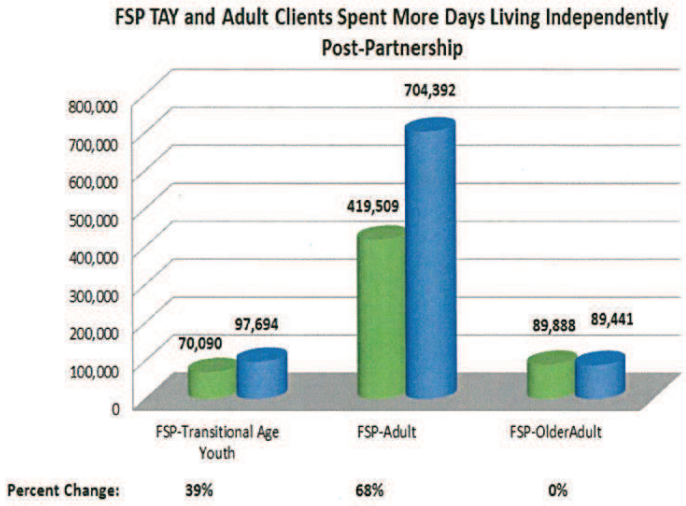


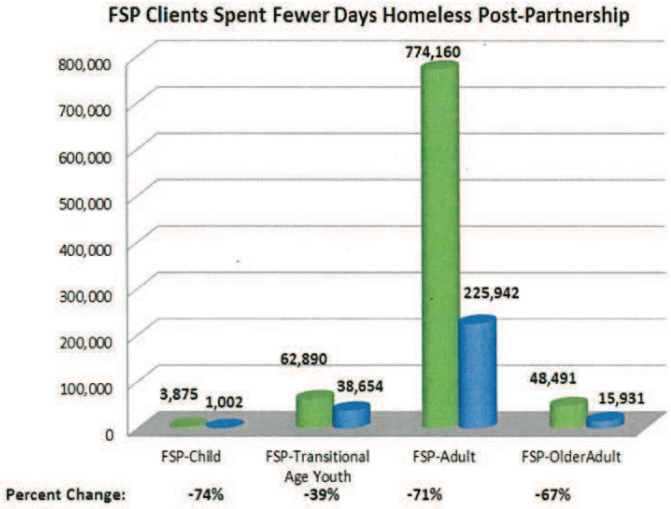
Fiscal Year 2012-13 Full Service Partnership Outcomes

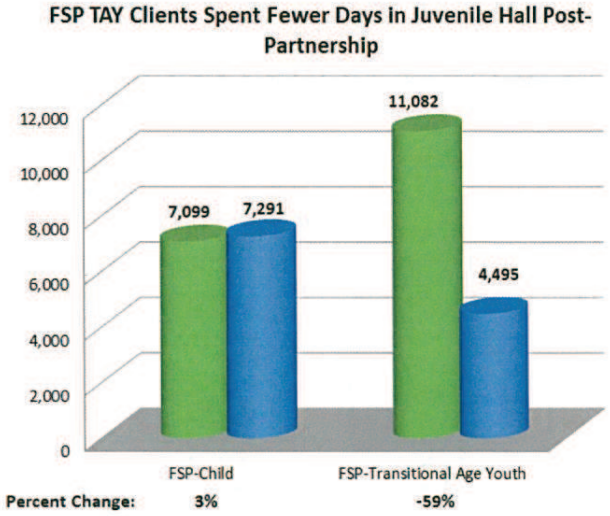
Residential

Number of Baselines Included (N) - Child: 6,135
Transitional Age Youth: 2,820
Adult: 7,812
Older Adult: 770



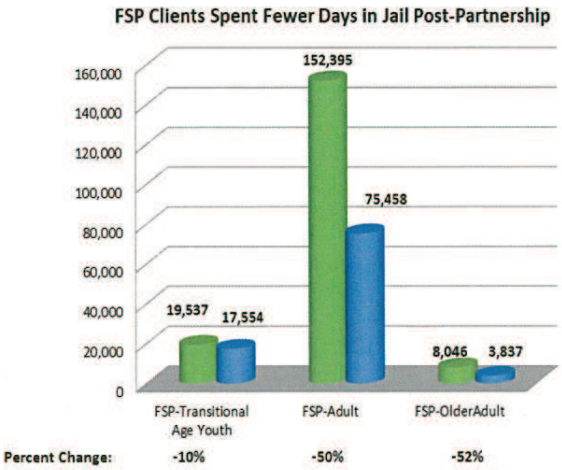


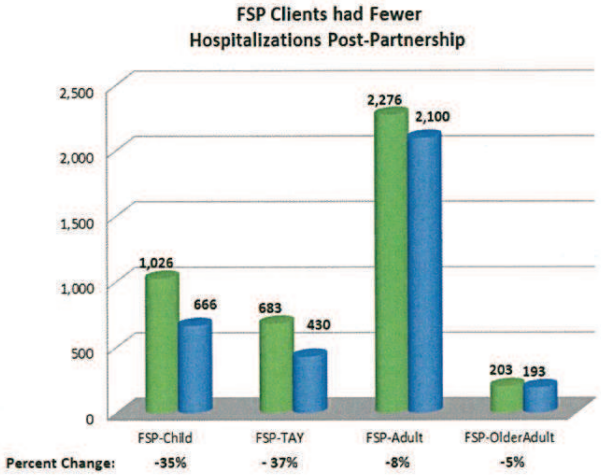


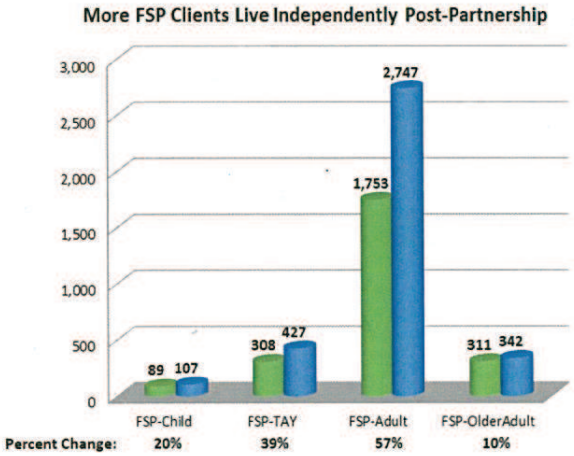


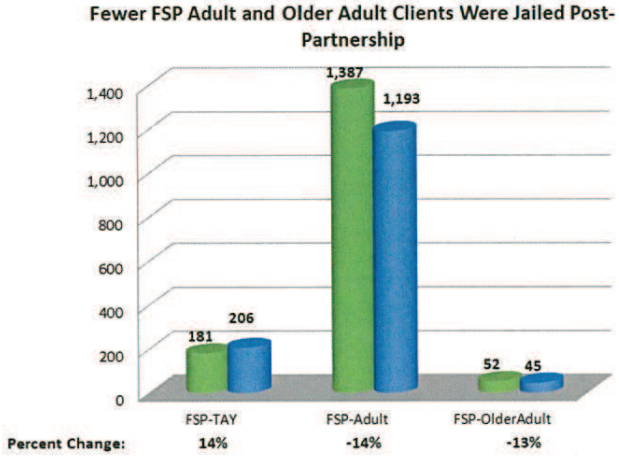
Pre Days

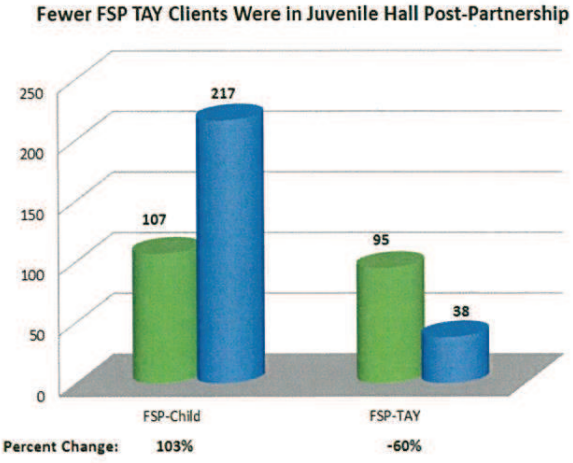
Post Days

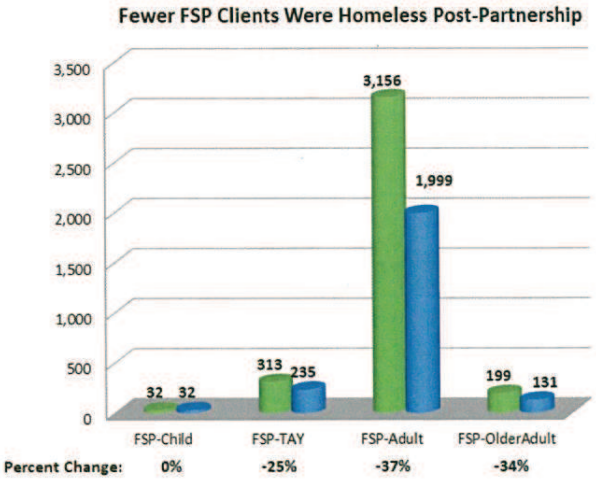








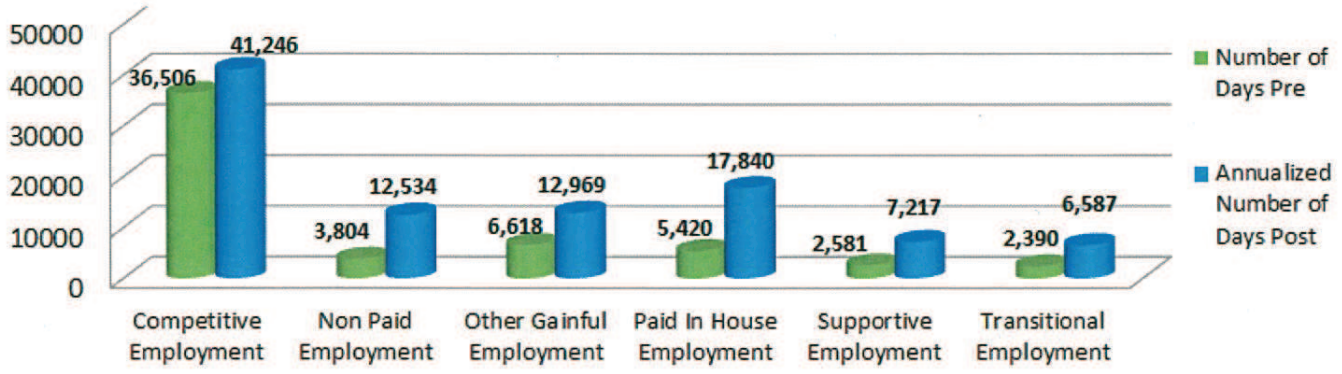




Pre Clients

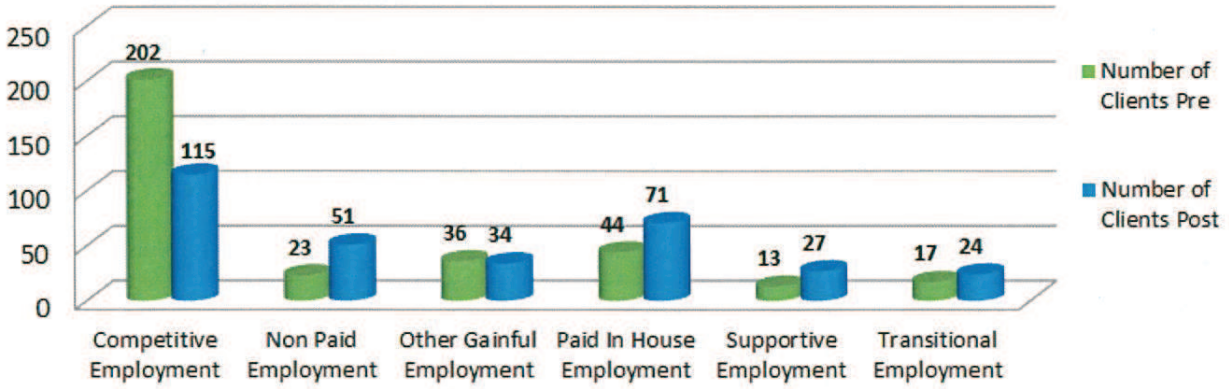
Post Clients

FSP Adult Clients Spent More Days in Positive Employment Post-Partnership



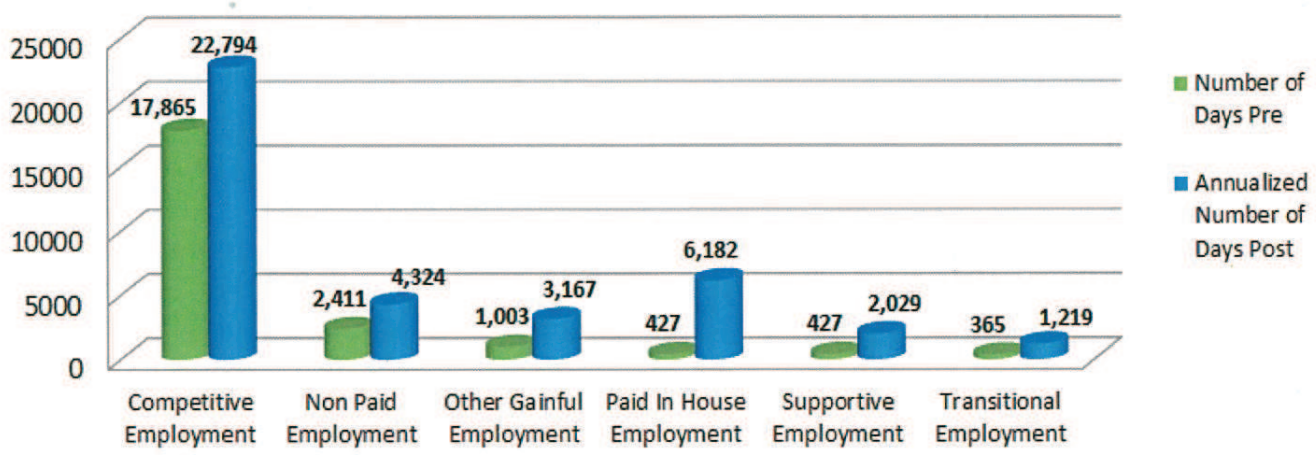
Percent Change:	11%	70%	49%	70%	64%	64%

More FSP Adult Clients Reported Positive Employment Outcomes Post-Partnership



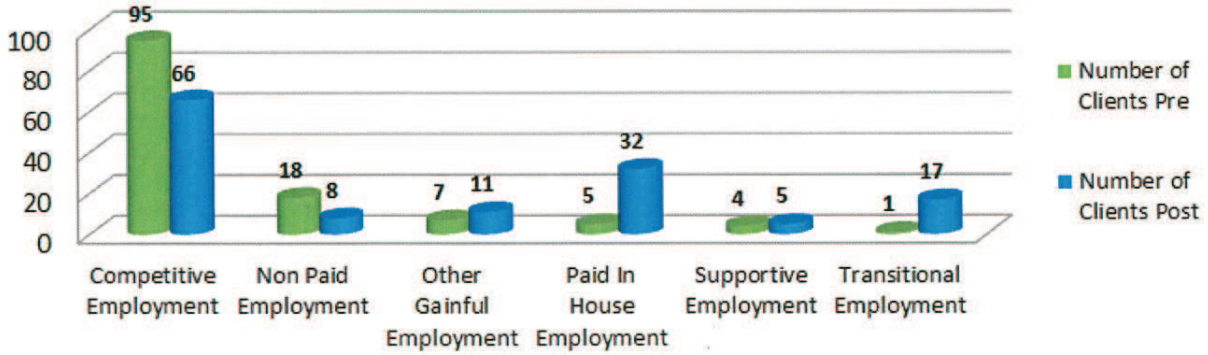
Percent Change:	-76%	55%	-6%	38%	52%	29%

FSP TAY Clients Spent More Days in Positive Employment Post-Partnership



Percent Change:	22%	44%	68%	93%	79%	70%

More FSP TAY Clients Reported Working in Other Gainful Employment, Paid In House Employment, Supportive Employment and Transitional Employment Post-Partnership

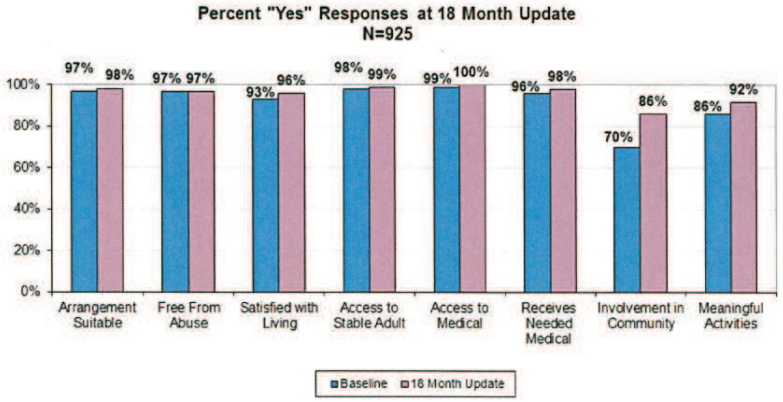


Percent Change:	-44%	-125%	36%	84%	20%	94%

Field Capable Clinical Services Outcomes

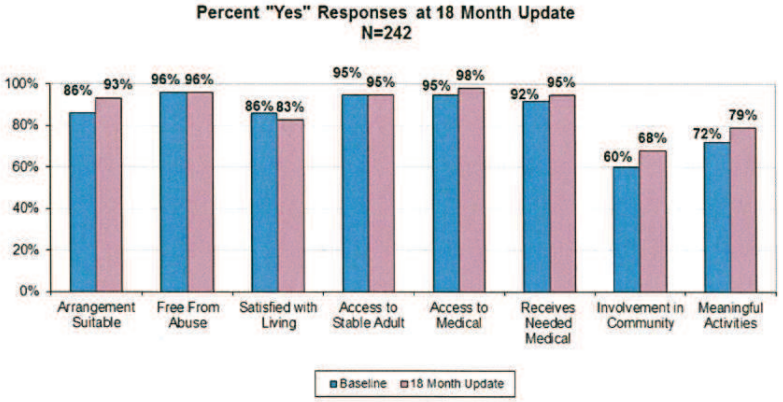
Child Program

Increased community involvement and engagement in meaningful activites:



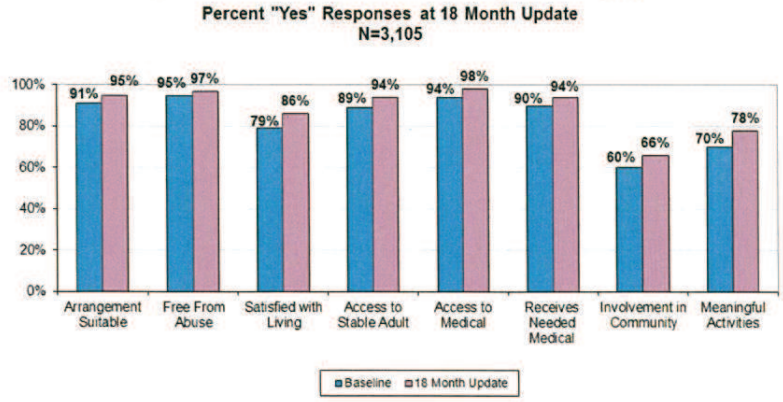
TAY Program

Increased community involvement, engagement in meaningful activites and receipt of needed medical care:



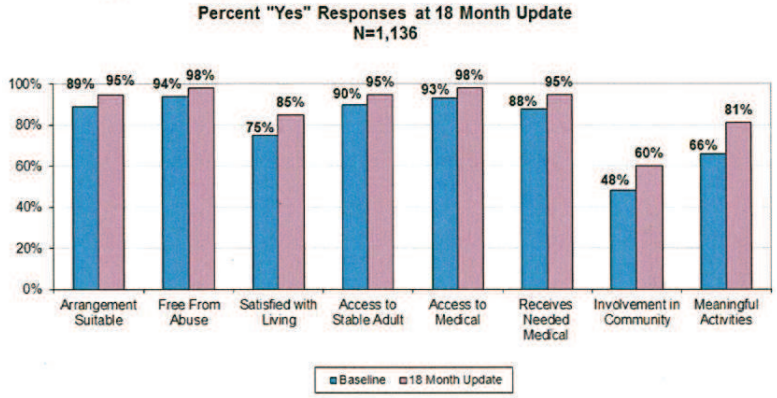
Adult Program

Increased satisfaction with living arrangements, access to a stable adult, access to medical care, receipt of needed medical care, involvement in the community and engagement in meaningful activities:



Older Adult Program

Increased suitability of living arrangements, access to social support, access to medical care, involvement in the community and engagement in meaningful activities:

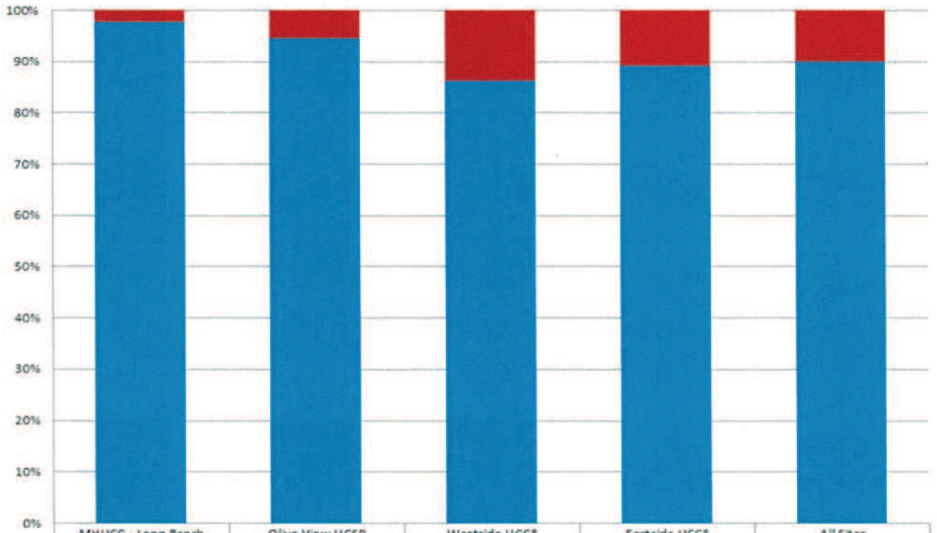


Alternative Crisis Services - Outcomes

July 1, 2012 through June 30, 2013 (FY 2012-13)

New Admissions to Urgent Care Centers (UCC) with Acute Psychiatric Inpatient Hospitalization within 30 Days of UCC Services

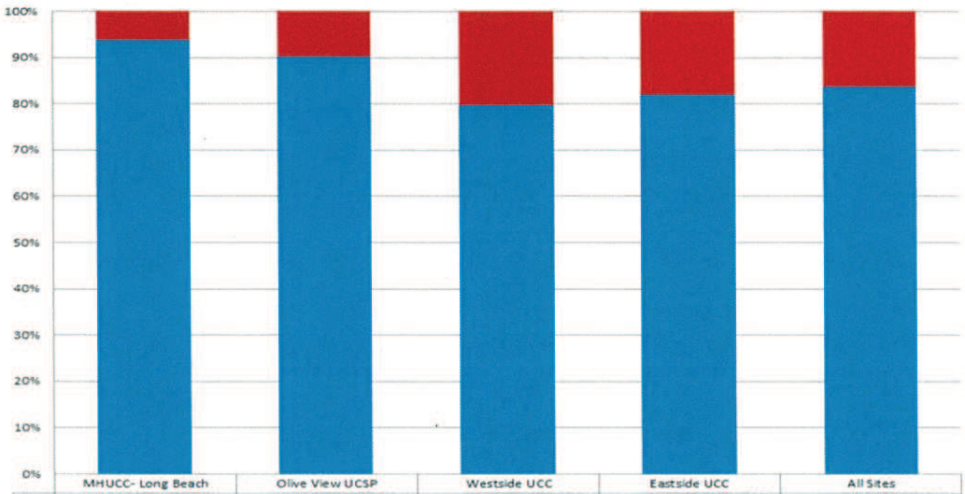
*89% of clients receiving UCC Services were **not** hospitalized within 30 days of the UCC visit.*



	MHUCC - Long Beach	Olive View UCSP	Westside UCC*	Eastside UCC*	All Sites
Yes	71 (2.4%)	109 (5.8%)	691 (16.0%)	1,593 (12.0%)	2,464 (11.0%)
No	2,923 (97.6%)	1,870 (94.2%)	4,309 (84.0%)	13,174 (88.0%)	22,276 (89.0%)

Any Inpatient, PMRT, ER Jail Contact within 30 Days of a UCC Assessment

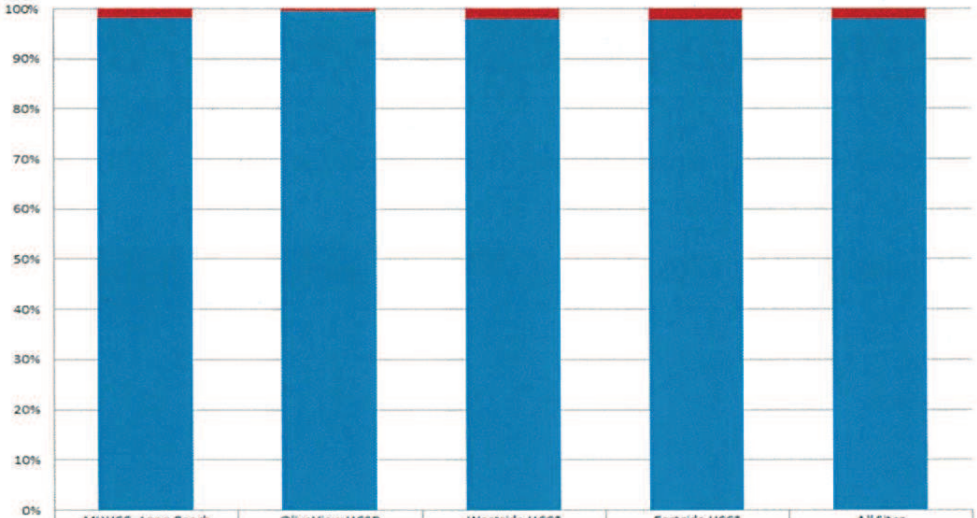
*84% of clients receiving a UCC assessment did **not** receive any Inpatient, PMRT, Psych ER or Jail MH contact within 30 days of the assessment.*



	MHUCC- Long Beach	Olive View UCSP	Westside UCC	Eastside UCC	All Sites
Yes	186 (6.6%)	192 (10.7%)	1,013 (20.0%)	2,659 (18.0%)	4,050 (16.3%)
No	2,808 (93.4%)	1,787 (89.3%)	3,987 (80.0%)	12,108 (82.0%)	20,690 (83.7%)

Any Contact with Jail Mental Health Services within 30 Days of being seen at a UCC

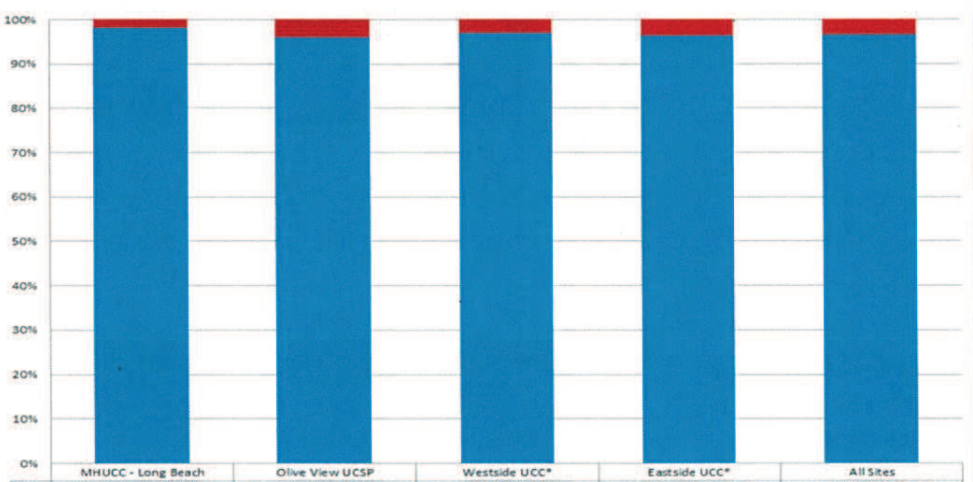
*98% of clients did **not** have any contact with Jail Mental Health Services within 30 days of being seen at a UCC.*



	MHUCC- Long Beach	OliveView UCSP	Westside UCC*	Eastside UCC*	All Sites
Yes	57 (1.9%)	9 (.45%)	108 (2.2%)	349 (2.4%)	523 (2.1%)
No	2,937 (98.1%)	1,970 (99.5%)	4,892 (97.8%)	14,418 (97.6%)	24,217 (97.9%)

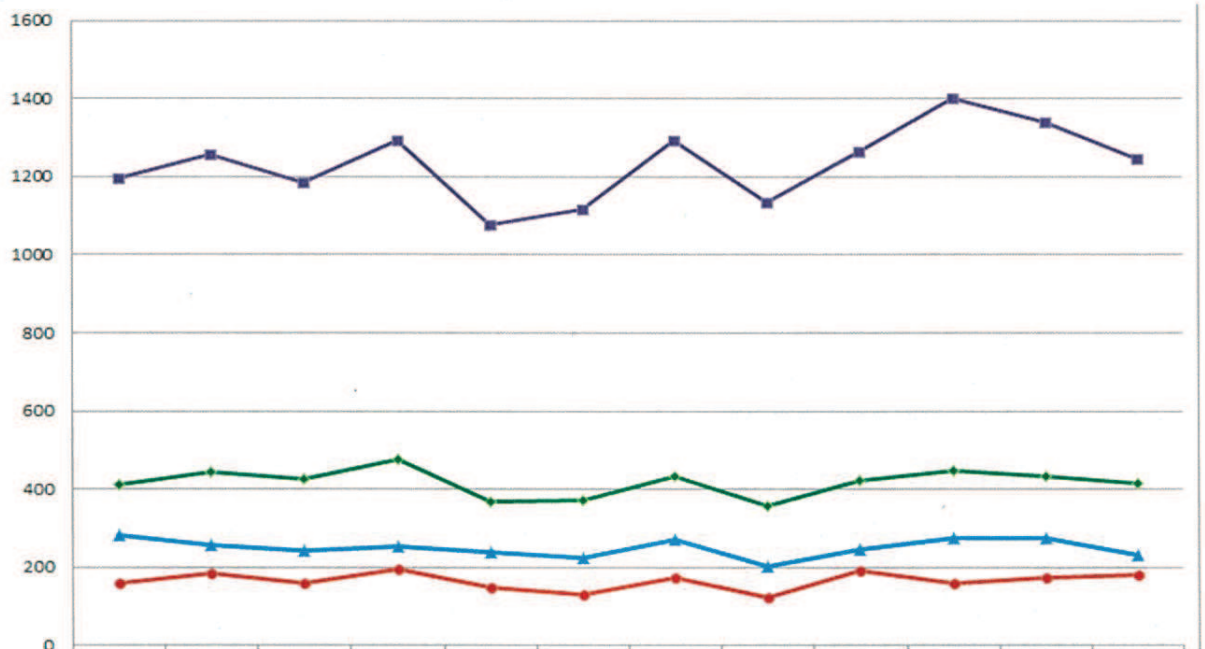
Any Visit to a Psychiatric Emergency Room within 30 Days of Being Seen at a UCC

*97% of clients did **not** have any visits to a Psychiatric ER within 30 days of being seen at a UCC.*



	MHUCC - Long Beach	Olive View UCSP	Westside UCC*	Eastside UCC*	All Sites
Yes	55 (1.8%)	79 (4.1%)	155 (3.1%)	546 (3.8%)	835 (3.4%)
No	2,939 (98.2%)	1,900 (95.9%)	4,845 (96.9%)	14,221 (96.2%)	23,905 (96.6%)

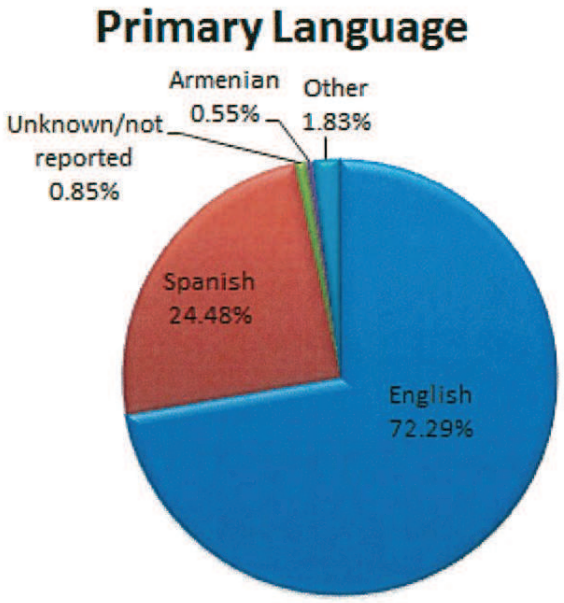
New Admissions to UCCs by Facility

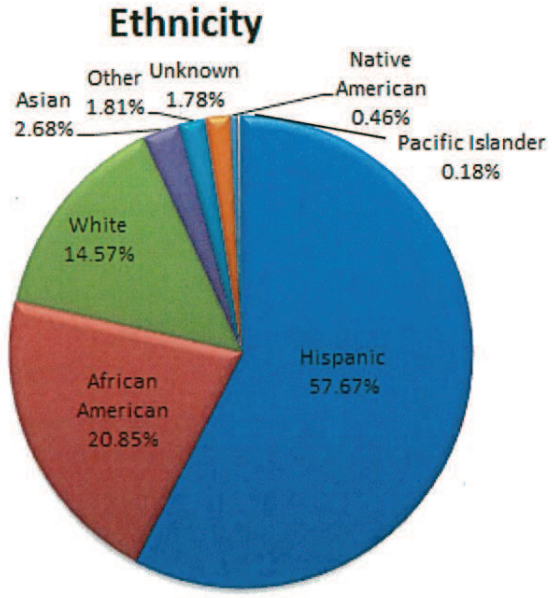


	Jul '12	Aug '12	Sep '12	Oct '12	Nov '12	Dec '12	Jan '13	Feb '13	Mar '13	Apr '13	May '13	Jun '13
MHUCC - Long Beach	281	258	241	253	239	223	272	201	246	275	274	231
Olive View UCSP	159	184	161	195	148	129	172	122	193	159	175	182
Westside UCC	412	442	426	477	367	373	431	356	422	447	434	413
Eastside UCC	1,195	1,255	1,184	1,291	1,078	1,117	1,292	1,136	1,264	1,401	1,339	1,245
All Sites	2,047	2,139	2,012	2,216	1,832	1,842	2,167	1,815	2,125	2,282	2,222	2,017

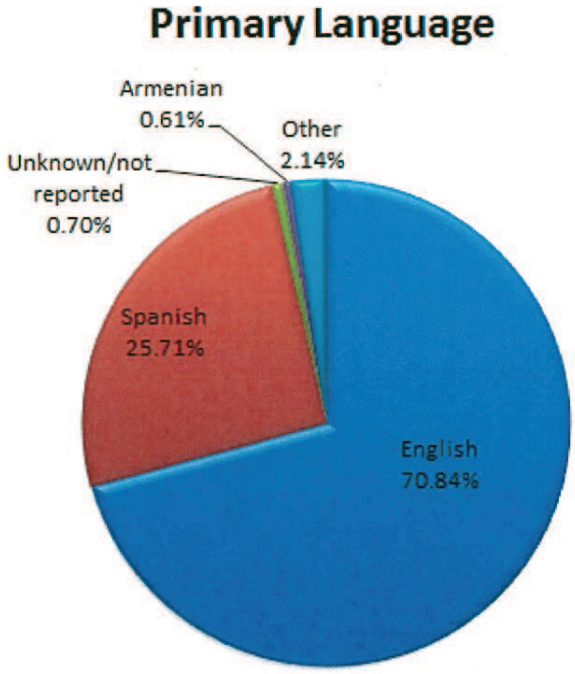
Prevention and Early Intervention

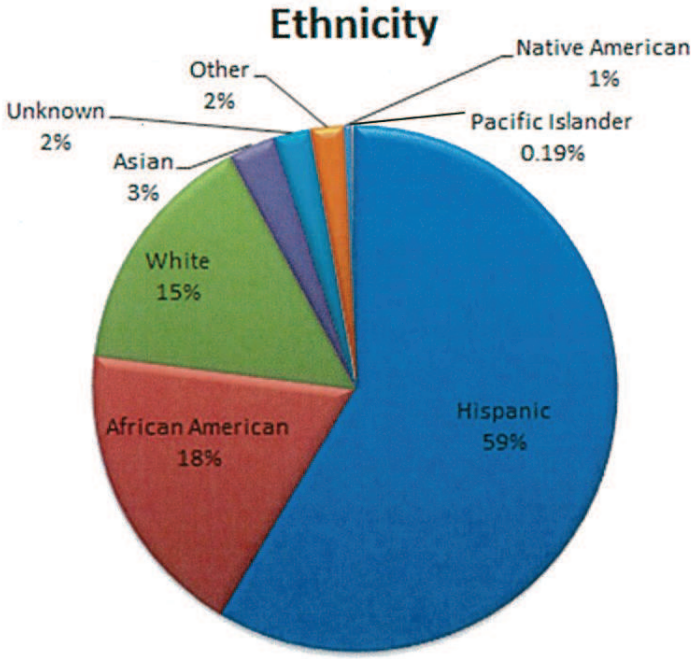
Unique Clients Receiving a Direct Mental Health Service through the PEI Plan: **73,140**





New Clients Receiving PEI Services Countywide with No Previous MHSA Service: **38,154**





Evidenced Based Practices (EBPs)

Number of Clients Served by EBP

Top 10 EBPs Delivered in the County

Managing and Adapting Practice

Unique Clients Served:	16,457
Average Cost per Client:	$4,138

Seeking Safety

Unique Clients Served:	11,849
Average Cost per Client:	$3,230

Trauma Focused CBT

Unique Clients Served:	11,404
Average Cost per Client:	$3,868

Crisis Oriented Recovery Services

Unique Clients Served:	4,987
Average Cost per Client:	$1,237

***Mental Health* Integration Program**

Unique Clients Served:	4,766
Average Cost per Client:	$814

Triple P Positive Parenting Program

Unique Clients Served:	4,212
Average Cost per Client:	$2,623

School Threat Assessment Response

Unique Clients Served:	3,607
Average Cost per Client:	$2,415

Interpersonal Psychotherapy for Depression

Unique Clients Served:	2,593
Average Cost per Client:	$2,517

Child Parent Psychotherapy

Unique Clients Served:	2,178
Average Cost per Client:	$3,788

Aggression Replacement Training

Unique Clients Served:	2,081
Average Cost per Client:	$2,458

Top 5 EBPs Delivered in the County by Age Group

Children

Managing and Adapting Practice - 13,308
Trauma Focused CBT - 9,490
Triple P Positive Parenting Program - 3,973
Seeking Safety - 2,726
School Threat Assessment Response Team - 2,387

Adult

Seeking Safety - 3,992
Mental Health Integration Program - 3,734
Crisis Oriented Recovery Services - 2,481
Individual Cognitive Behavioral Therapy - 1,380
Interpersonal Psychotherapy for Depression - 913

TAY

Seeking Safety - 4,718
Managing and Adapting Practice - 3,124
Trauma Focused CBT - 1,846
School Threat Assessment Response Team - 1,164
Aggression Replacement Training - 885

Older Adult

Mental Health Integration Program - 613
Interpersonal Psychotherapy for Depression - 415
Seeking Safety - 413
Crisis Oriented Recovery Services - 197
Problem Solving Therapy – 159

PEI Outcomes

PEI metrics were chosen based on input from practice developers, a review of the outcome measure literature and input from providers and other stakeholders. In addition, cost, length of instrument and languages an instrument has been translated into were factors related to measures selection.

A general measure and focus of treatment specific measure is administered at the beginning of treatment and at the end of treatment, with pre- and post-treatment changes analyzed. If the treatment lasts greater than six months, both measures are given again at the six-month marker.

While DMH has focused most of its initial PEI evaluation efforts on outcome measures training, use of the PEI OMA (web-based application) and identifying successful strategies to increase the percentage of pre-post matched comparisons in order to evaluate the effectiveness of PEI, the following trends are emerging in terms of the effectiveness of evidence-based practices for a PEI population:

At the program level:

Managing and Adapting Practice (MAP): This practice encompasses several foci of treatment, including anxiety, trauma, depression and disruptive behavior disorders. While the matched pairs are relatively low at this point, both children and parent/caregivers have endorsed the strongest positive change related to the treatment of disruptive behavior disorders, with **67%** of parents endorsing positive change on the Youth Outcome Questionnaire (YOQ) and **57%** endorsing positive change on the Eyberg Child Behavior Inventory (ECBI), **40%** of children endorsing positive change on the YOQ-SR, and **55%** endorsing positive change on the ECBI. Overall, matched pair results to date indicate that parent/caregivers are endorsing positive change related to MAP **64%** of the time, with a **45%** improvement in functioning achieved and children are endorsing positive change **55%** of the time, with a **41%** improvement in functioning achieved. All comparisons are made at the beginning and at the end of treatment.

Triple P Parenting: This practice aimed at reducing parenting and family difficulties has resulted in a **38%** positive change as endorsed by parents and a **22%** positive change as endorsed by children on the YOQ-SR. The practice has also demonstrated 58-60% positive reliable change in parent/caregiver ECBI scores.

Trauma Focused Cognitive Behavioral Therapy: For the 64 agencies providing trauma focused services, **74%** of the recipients of this practice self-identify as Latino. Both children and parent/caregivers have endorsed positive change on the YOQ. Parents endorsed a **38%** improvement in their children's overall functioning, while children reported a **35%** improvement in their overall functioning, representing **51%** and **47%** reliable change percentage, respectively. On average, parents report a **37%** improvement and children report a **42%** improvement in trauma symptoms on the Post Traumatic Stress Disorder Reaction Index (PTSD-RI) after completing Trauma Focused Cognitive Behavioral Therapy.

Incredible Years: This practice aimed at improving parenting skills and reducing family difficulties has an average client age of 8. Sixty-six percent of clients are male and **81%**are Latino. A comparison between pre and post-average scores for the ECBI and the YOQ shows a reduction in symptoms below the clinical cutoff. Reductions in average scores range from **17% to 33%.**

Group CBT for Depression: This practice aimed at reducing early course depression has demonstrated on average a **35%** reduction in symptoms as measured by the PHQ-9 and a **21%** reduction in overall symptoms as measured by the Outcome Questionnaire (OQ-45.2), representing **38% to 43%** positive reliable change respectively.

Aggression Replacement Training (ART): Sixteen agencies are providing this practice aimed at treating disruptive behavior disorders in 12-17 year olds. When comparing pre and post-treatment average scores for the ECBI, the practice has led to **14 to 25%** reductions in symptoms and **11 to 25%** reductions in average scores pre and post-treatment on the YOQ-Parent and YOQ-SR.

Seeking Safety: A robust implementation involving 73 contract agencies and county-operated programs has demonstrated, as measured by the PTSD-RI and the Outcome Questionnaire/YOQ-SR & YOQ (parent and self-report), significant reductions in trauma. Average symptom reduction after completion of the practice for children and their parent/caregiver ranges from **29% to 35%** depending upon the questionnaire. Average symptom reduction for adults aged 18 and above is **20%**, with reductions seen below the clinical cutoff for the PTSD-RI for adults.

Child Parent Psychotherapy: Thirty-one contract agencies and county operated programs are providing this practice geared to treat trauma in young children ages 0–6 and their parent/caregivers. This practice has yielded a **62%** improvement in trauma symptoms as measured by the YOQ-Parent.

Crisis Oriented Recovery Services (CORS): Thirty-two contract and county operated programs are providing this brief treatment model to address situational crises. Adults and children who completed the six session model experience a **21%** improvement as measured by the OQ 45.2 and YOQ-SR respectively. Parents reported a **33%** improvement in their child's symptoms.

Innovation

The following is an overview of the Innovation program, outcomes for the first year of program implementation, and highlights of the lessons learned and considerations for the second year of implementation.

Innovation Program Overview

The overall goal of the MHSA-funded Innovation (INN) Program is to identify new practices with the primary goal of learning and exploring creative and effective approaches that can be applied to the integration of mental health, physical health, and substance use services for uninsured, homeless, and underrepresented populations.

In order to achieve the goals of the INN program, four models of care have been developed, each focusing on innovative recruitment and care delivery services.

The Integrated Clinic Model (ICM) model is designed to improve access to high quality, culturally competent care for individuals with physical health, mental health, and co-occurring substance use diagnoses by integrating care within both mental health and primary care provider sites.

The Integrated Mobile Health Team Model (IMHT) model is designed as a client-centered, housing-first approach that uses harm reduction strategies across all modalities of mental health, physical health, and substance abuse treatment. IMHT particularly focuses on individuals who are homeless or recently moved to Permanent Supportive Housing (PSH) and are considered to have vulnerabilities such as age, years homeless, co-occurring substance abuse disorders, and/or physical health conditions.

The Community-Designed Integrated Services Management Model (ISM) model provides a holistic model of care, the components of which are defined by specific ethnic communities and which promote collaboration and community based partnerships to integrate health, mental health, and substance abuse services together with other needed non-traditional care to support recovery. The ISM model is divided into five ethnic models: African Immigrant/African American, American Indian/Alaskan Native, Asian Pacific Islander, Eastern European/Middle Eastern, and Latino.

Lastly, the Integrated Peer-Run Model serves individuals with mental health needs who also have additional health and/or substance abuse treatment needs by providing programs that are designed and run by people with lived experience of mental health issues.

In order to evaluate the implementation and obtainment of program goals, LACDMH contracted an evaluation team comprising University of California, San Diego's Health Services Research Center (HSRC), Harder+Company Community Research, and the University of Southern California (USC).

On July 17, 2013 the System Leadership Team approved a motion to extend the Innovation Project so that each model will have 3 fiscal years to engage in the learning described above. As such, the Integrated Clinic Model, Community-designed Integrated Services Management Model, and Integrated Mobile Health Team Model will be extended through FY 2014-15 and the Integrated Peer Run Model will be extended through the end of Fiscal Year 2015-16.

Year One Learning Sessions

The evaluation team helped design and facilitate four learning sessions during year one. Learning sessions were designed to support the implementation of INN by creating opportunities for providers and LACDMH to identify common challenges and recognize potential best practices as they develop in real-time. The intent of Learning Sessions is to

support INN program implementation in the short run and strengthen networks of relationships among providers throughout Los Angeles County.

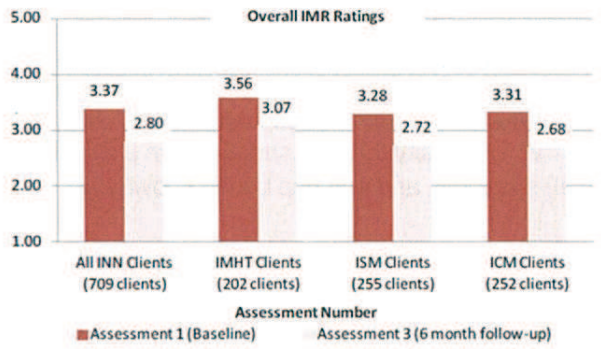
Initial Learning Sessions were primarily conceptualized and led by LACDMH and evaluation team members. Over time, there has been an intentional shift in the focus of Learning Sessions, so that at least half of each session involves provider-led panel discussions and small group activities designed to facilitate sharing and learning. Learning Session participants are encouraged to nominate topics for each Learning Session to ensure sessions are relevant and useful to providers. Following Learning Sessions II-IV, Learning Briefs were produced and shared with providers in order to document the activities, challenges, and innovations that emerged during each meeting. Learning Briefs consist of a summary of the session's activities, highlights of key findings, and extensive appendices capturing table notes and group ideas with the goal of extending learning opportunities beyond the session.

Year One Enrollment and Evaluation Outcomes

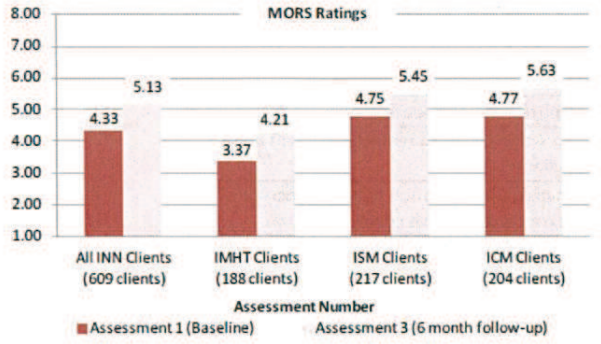
To date, a total of 2,649 clients (one in 2011, 1,419 in 2012, and 1,229 in 2013) have enrolled in INN programs. Current INN clients are most likely to be between the ages of 48 to 59 (34.6%), and Latino/a (35.0%) or African/African American (28.4%). Gender was almost evenly split between males and females.

Measures were selected based on goals across all models, and included validated measures and health indicators. Findings on some of the key outcomes at the six month time point are presented below.

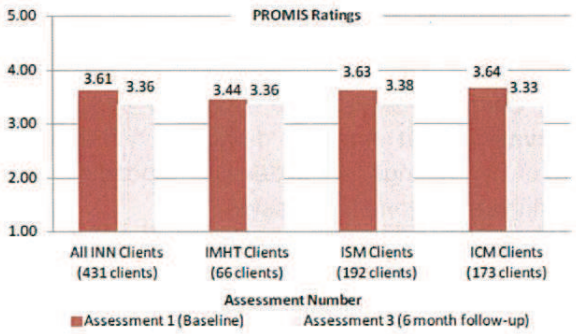
On the clinician-completed Illness Management and Recovery Scale (IMR), there were significant reductions in scores from the baseline assessment to the six month assessment for each of the INN models. This indicates that clients were better able to manage their mental health and made progress towards their recovery. There were also significant overall reductions on each of the three IMR subscales: Recovery, Management, and Substance Use.



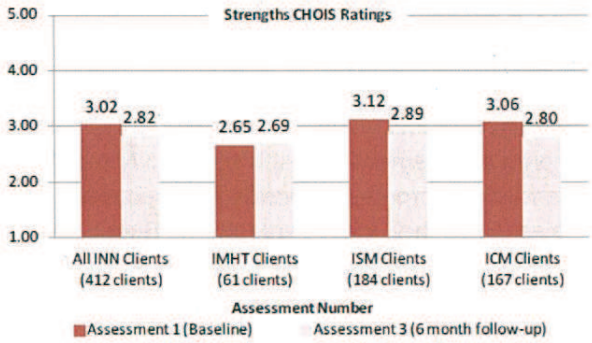
There were significant increases in scores on the clinician-completed Milestones of Recovery Scale (MORS) from the baseline assessment to the six month assessment for each of the INN models. This indicates that clients were in more advanced stages of recovery after participating in INN for six months.



Scores on the client-completed PROMIS Global Health Scale were significantly reduced for ISM and ICM clients from the baseline assessment to the six month assessment. This indicates that ISM and ICM model clients experienced less impairment due to their physical and mental health.



On the client-completed CHOIS supplement, there were significant reductions in the Strengths subscale from the baseline assessment to the six month assessment for clients in the ISM and ICM models. This indicates that ISM and ICM model clients had greater recovery-oriented personal strengths after receiving INN services for six months.



Clients also completed the Internalized Stigma of Mental Illness scale (ISMI) to assess mental health related stigma. There was a significant reduction in ISMI scores from baseline to six months for ISM clients. This indicates that clients in the ISM model were less likely to feel stigmatized based on their mental health at the six month assessment.
The tool was developed at Case Western Reserve University through support from a SAMHSA grant and incorporates the best available evidence – combining theoretical, empirical, and practice based knowledge.

Initial Lessons Learned

While ITT site visits focused on individual programs, there are lessons learned from this implementation evaluation that are applicable across individual programs and INN models. These lessons pertain to barriers and facilitators of integrated care that exist at the individual, program, and systems levels. A summary of these lessons learned is provided in the table below.

Initial Lessons Learned from ITT
#1: There are developmental stages of integration.
#2: Policies/procedures and CQI are in early stages of development.
#3: Peer specialist roles are still evolving.
#4 - Interdisciplinary team meetings work.
#5: Effective care coordination requires efficient and timely communication.
#6: Innovation programs continue to face numerous barriers to maximizing effective communication.
#7: Care manager role and duties are typically shared by more than one person or a full team.
#8: The CCCP is a perceived barrier to integrated care planning.
#9: There are opportunities for training.
#10: Programs are preparing to become data driven.

A full summary of each lesson learned is provided in the full report, but the following includes three of the major lessons learned.

There are developmental stages of integration. Most INN programs represent new organizational partnerships and have experienced "growing pains" to different degrees.

In some cases these growing pains have resulted in the termination of certain partnerships (e.g., dissolution of agreement between FQHC and mental health provider) and in other cases have resulted in additional plans to expand the scope of the relationship (e.g., plans to develop newly formed, co-located clinics). Although there has not been a single, clear trajectory among all programs, INN programs that are more fully integrated have gone through a process in which organizational boundaries get blurred and the INN program is embraced by and central to all partners' missions. This translates into a change from identifying problems that are separately faced by each organizational partner into addressing challenges as a shared responsibility between all partners.

Interdisciplinary team meetings work. This seemingly obvious statement is supported by programs that convene interdisciplinary meetings, those that do not, and those that take a hybrid approach. A hybrid approach refers to programs that may hold a series of meetings that involve different disciplines (e.g., meeting with mental health therapist and psychiatrist, mental health therapists and addiction specialists, care manager and primary care provider) but do not have a venue for all team members to meet together to discuss patient care. Treatment team meetings support integrated care in the following ways:

- *By facilitating interdisciplinary communication and care coordination.*
- *By providing a venue for group supervision and case review.*
- *By offering an opportunity for cross disciplinary training.*

INN programs continue to face numerous barriers to maximizing effective communication and coordination of care. Most notable were regulatory or perceived-regulatory barriers to interdisciplinary communication (e.g. HIPAA violations). Although most programs established protocols that would allow for communication between mental health, substance abuse, and primary care providers (e.g., joint release of information), there were still some programs that have not crossed that divide. There were also several barriers to improved communication that relate specifically to suggestions made within the ITT to utilize electronic health records (EHR), telemedicine, and patient-portals or websites.

Considerations for Year Two

During the first year of INN, providers continuously adapted their outreach efforts and service offerings to best meet the needs of their target populations. As best practices are established and implemented in year two, these changes will likely be reflected in the outcome measures. Additionally, as more clients are enrolled, the evaluation team will be better able to conduct more detailed statistical analyses.

Clients Served for FY 2012-13

Community-Designed Integrated Services Management Model

Unique Clients Served: 1,060

Cost: $4,829,335

Average Cost per Client: $4,556

Integrated Clinic Model

Unique Clients Served: 1,108

Cost: $3,120,826

Average Cost per Client: $2,817

Integrated Mobile Health Team

Unique Clients Served: 473

Cost: $6,020,797

Average Cost per Client: $12,729

Learning Sessions

Working in partnership with LACDMH staff, the evaluation team designed and facilitated four Learning Sessions during year one. Learning sessions were designed to support the implementation of INN by creating opportunities for providers and LACDMH to identify common challenges and recognize potential best practices as they develop in real-time. The intent of Learning Sessions is to support INN program implementation in the short run and strengthen networks of relationships among providers in Los Angeles County. The graphic timeline below illustrates the timing and topical focus of each of the year one learning sessions.

Initial Learning Sessions were primarily conceptualized and led by LACDMH and evaluation team members. Over time, the team has intentionally shifted the focus of Learning Sessions, so that at least half of each session involves provider-led panel discussions and small group activities designed to facilitate sharing and learning. Learning Session participants are encouraged to nominate topics for each Learning Session to ensure sessions are relevant and useful to providers. Continuing education (CEU) hours were offered at two of the first year sessions to increase the value to participants.

Typically organizations bring between two and five team members, and include a mix of administrative and clinical staff. While some organizations have opted to bring the same core set of staff members, others alternate attendance at each session, often with the program director attending consistently and other program staff attending based on interest in agenda topics and availability.

After providing detailed notes to LACDMH for Learning Session I, the team proposed to produce a more comprehensive summary of Learning Session activities that could be shared with participants, which have developed into four to six page "Learning Briefs." Learning Briefs were produced following Learning Sessions II-IV in order to document the activities, challenges, and innovations that emerged during each meeting. Learning Briefs consist of a summary of the session's activities, highlights of key findings and extensive appendices capturing table notes and group ideas with the goal of extending learning opportunities beyond the session.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
Program Support Bureau - MHSA Implementation and Outcomes Division
Prevention & Early Intervention (PEI) Evidence-Based Practices (EBP) Outcome Measures

FOCUS OF TREATMENT	EBP, CDE, PP	AGE	GENERAL OUTCOME MEASURE	AGE	SPECIFIC OUTCOME MEASURE	Age	AVAILABLE THRESHOLD LANGUAGES
ANXIETY	Managing and Adapting Practice (MAP) - *Anxiety & Avoidance* **	3 - 19	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	Revised Child Anxiety and Depression Scales (RCADS) - Parent Revised Child Anxiety and Depression Scales (RCADS) - Child	6 - 18 6 - 18	Chinese, English, Spanish, Korean
	Individual Cognitive Behavioral Therapy - Anxiety (CBT-Anxiety)	18+	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	18 19+	Generalized Anxiety Disorder - 7 (GAD-7)	18+	Arabic, Chinese, English, Korean, Russian, Spanish, Tagalog
	Mental Health Integration Program (MHIP) - Anxiety	18 - 60+	No general measure is required				
TRAUMA	Child Parent Psychotherapy (CPP)	0 - 6	Youth Outcome Questionnaire - 2.01 (Parent)	4 - 17	Trauma Symptom Checklist for Young Children (TSCYC)	3 - 6	Chinese, English, Korean, Spanish, Armenian
	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	10 - 15	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18	UCLA PTSD-Reaction Index for Children and Adolescents (UCLA PTSD-RI) – Parent UCLA PTSD-Reaction Index for Children and Adolescents (UCLA PTSD-RI) – Child/Adolescents	3 - 18 6 - 20	**Adult** - English **Parent** - English, Chinese, Japanese, Russian, Spanish **Child/Adolescent** - English **Child** - Chinese, Farsi, Japanese, Russian, Spanish **Adolescent** - Chinese, Spanish
	Alternatives for Families-Cognitive Behavioral Therapy [formerly: Abuse Focused-Cognitive Behavioral Therapy] (AF-CBT)	6 - 15					
	Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) *	3 - 18					
	Managing and Adapting Practice (MAP) - *Traumatic Stress* **	2 - 18					
	Seeking Safety (SS)	13 - 60+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	UCLA PTSD-Reaction Index for Children and Adolescents (UCLA PTSD-RI) – Parent UCLA PTSD-Reaction Index for Children and Adolescents (UCLA PTSD-RI) – Child/Adolescents UCLA PTSD-Reaction Index (UCLA PTSD-RI) – Adult Short Form	3 - 18 6 - 20 21+	
	Individual Cognitive Behavioral Therapy -Trauma (CBT-Trauma)	18+	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	18 19+	UCLA PTSD-Reaction Index for Children and Adolescents (UCLA PTSD-RI) – Child/Adolescents UCLA PTSD-Reaction Index (UCLA PTSD-RI) – Adult Short Form	18 - 20 21+	
	Prolonged Exposure for PTSD (PE)	18 - 70	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	18 19+	Posttraumatic Stress Diagnostic Scale (PDS)	18 - 65	English
	Mental Health Integration Program (MHIP)-Trauma	18 - 60+	No general measure is required		PTSD Checklist-Civilian (PCL-C)	18+	Chinese, English, Spanish

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Prevention & Early Intervention (PEI) Evidence-Based Practices (EBP) Outcome Measures

FOCUS OF TREATMENT	EBP, CDE, PP	AGE	GENERAL OUTCOME MEASURE	AGE	SPECIFIC OUTCOME MEASURE	Age	AVAILABLE THRESHOLD LANGUAGES
CRISIS	Crisis Oriented Recovery Services (CORS)	3+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	No specific measure required		
FIRST BREAK / TAY	Center for the Assessment and Prevention of Prodromal States (CAPPS)	16 - 25	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	Scale of Prodromal Symptoms (SOPS)	12 -35	English, Spanish
DEPRESSION	Interpersonal Psychotherapy for Depression (IPT)	12 - 60+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	Patient Health Questionnaire - 9 (PHQ-9)	12+	Arabic, Chinese, English, Korean, Russian, Spanish, Tagalog, Japanese
	Depression Treatment Quality Improvement (DTQI)	12 - 20					
	Managing and Adapting Practice (MAP) - *Depression and Withdrawal* **	8 - 21					
	Group Cognitive Behavioral Therapy for Major Depression (Group CBT for Major Depression)	18+	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	18 19+	Patient Health Questionnaire - 9 (PHQ-9)	18+	Arabic, Chinese, English, Korean, Russian, Spanish, Tagalog, Japanese
	Individual Cognitive Behavioral Therapy - Depression (CBT-Depression)	18+					
	Problem Solving Therapy (PST)	60+	Outcome Questionnaire - 45.2	19+			
	Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)	60+					
	Mental Health Integration Program (MHIP) - Depression	18 - 60+	No general measure is required				

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Prevention & Early Intervention (PEI) Evidence-Based Practices (EBP) Outcome Measures

FOCUS OF TREATMENT	EBP, CDE, PP	AGE	GENERAL OUTCOME MEASURE	AGE	SPECIFIC OUTCOME MEASURE	Age	AVAILABLE THRESHOLD LANGUAGES
EMOTIONAL DYSREGULATION DIFFICULTIES	Dialectical Behavioral Therapy (DBT) DIRECTLY OPERATED CLINICS	18+	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	18 19+	Difficulties in Emotional Regulation Scale (DERS)	18+	English
DISRUPTIVE BEHAVIOR DISORDERS	Aggression Replacement Training (ART)	12 - 17	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18	Eyberg Child Behavior Inventory (ECBI) Sutter Eyberg Student Behavior Inventory - Revised (SESBI-R) [If parent is unavailable]	2 – 16 2 – 16	ECBI: Armenian, Chinese, English, Japanese, Korean, Russian, Spanish SESBI-R: Arabic, Armenian, Chinese, English, Russian, Spanish, Japanese
	Aggression Replacement Training - ***Skillstreaming*** (ART)	5 - 12					
	Promoting Alternative THinking Strategies (PATHS)	3 - 12					
	Managing and Adapting Practice (MAP) - *Disruptive Behavior* **	0 - 21	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+			
SEVERE BEHAVIORS / CONDUCT DISORDERS	Brief Strategic Family Therapy (BSFT)	10 - 18	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18	Revised Behavior Problem Checklist - Parent (RBPC) Revised Behavior Problem Checklist - Teacher (RBPC) [If parent is unavailable]	5 – 18 5 - 18	Cambodian, English
	Multidimensional Family Therapy (MDFT)	11 - 18					
	Strengthening Families Program (SFP)	3 - 16					
	Functional Family Therapy (FFT)	10 - 18	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18	**Developer Required:** Clinical Services System: • Counseling Process Questionnaire • Client Outcome Measure • Therapist Outcome Measure • YOQ/YOQ-SR/OQ	10 - 18	English
	Multisystemic Therapy (MST)	11 - 17			**Developer Required:** Therapist Adherence Measure Supervisor Adherence Measure	11 - 17	English

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Prevention & Early Intervention (PEI) Evidence-Based Practices (EBP) Outcome Measures

FOCUS OF TREATMENT	EBP, CDE, PP	AGE	GENERAL OUTCOME MEASURE	AGE	SPECIFIC OUTCOME MEASURE	Age	AVAILABLE THRESHOLD LANGUAGES
PARENTING and FAMILY DIFFICULTIES	Triple P Positive Parenting Program (Triple P)	0 - 18	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18	Eyberg Child Behavior Inventory (ECBI) Sutter Eyberg Student Behavior Inventory-Revised (SESBI-R) [If parent is unavailable]	2 – 16 2 – 16	ECBI: Armenian, Chinese, English, Japanese, Korean, Russian, Spanish SESBI-R: Arabic, Armenian, Chinese, English, Russian, Spanish
	Incredible Years (IY)	0 - 12					
	Parent – Child Interaction Therapy (PCIT)	2 - 7					
	UCLA TIES Transition Model (UCLA TIES) CDE	0 - 9					
	Caring For Our Families (CFOF) CDE as of 12/1/12	5 - 11					
	Loving Intervention Family Enrichment (LIFE) CDE as of 12/1/12	10 - 17					
	Reflective Parenting Program (RPP) CDE	0 - 12					
	Mindful Parenting Groups (MPG) CDE	0 - 3	No general measure is required		Devereux Early Childhood Assessment for Infants and Toddlers (DECA-I/T)	1m - 36m	English, Spanish
	Caring For Our Families (CFOF) CDE prior to 12/1/12	5 - 11	Youth Outcome Questionnaire - 2.01 (Parent)	4 - 17	As of 12/1/12 the Eyberg Child Behavior Inventory (ECBI) and the Sutter Eyberg Student Behavior Inventory-Revised (SESBI-R) [If parent is unavailable] are being used for all new clients instead of the Child Behavior Checklist for Ages 1 ½ - 5 (CBCL 1.5-5) Child Behavior Checklist (CBCL) Caregiver-Teacher Report Form for Ages 1 ½ - 5 (C-TRF) Teacher Report Form (TRF) Youth Self-Report (YSR)	2 – 16 2 – 16	ECBI: Armenian, Chinese, English, Japanese, Korean, Russian, Spanish SESBI-R: Arabic, Armenian, Chinese, English, Russian, Spanish, Japanese
	Loving Intervention Family Enrichment (LIFE) CDE prior to 12/1/12	10 - 17	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18			
	Nurse Family Partnerships (NFP)	11 - 35	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	Patient Health Questionnaire – 9 (PHQ-9) Ages & Stages Questionnaires (ASQ) Parenting Stress Index, 3rd Edition (PSI)	12 – 35 3mos+ 3mos+	PHQ - 9: Arabic, Chinese, English, Spanish, Tagalog, Japanese, Korean, Russian ASQ & PSI: English
	Families OverComing Under Stress (FOCUS)	5+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	McMaster Family Assessment Device (FAD)	12+	English

* Outcome collection for TF-CBT should have begun in December 2010 (MHSA Implementation Memo, dated 12/14/2010).

** Providers should have begun collecting outcomes for MAP-Anxiety and Avoidance, MAP-Traumatic Stress, and MAP-Depression and Withdrawal in February 2011 (MHSA Implementation Memo, dated 2/22/2011).

PEI EBPs that are not entered into PEI OMA are shaded.

1. Youth Outcome Questionnaire - 2.01 (Parent); Youth Outcome Questionnaire-Self-Report - 2.0; and Outcome Questionnaire - 45.2 are available in all 13 threshold languages: English, Arabic, Armenian, Cambodian, Chinese (Modern), Chinese (Traditional), Farsi, Tagalog, Japanese, Korean, Russian, Spanish, and Vietnamese.